WHAT TO EXPECT ONCE APPLICATION IS SUBMITTED

Please add our email address speechandhearing@dca.ca.gov to your contact list. We will email you regarding your application whenever possible.

Please be sure all sections of this application are completed properly with the original signatures of each person to avoid your application being returned.

You will receive an acknowledgment email within 2 weeks of the Board receiving your application packet. This email will provide important information including the processing time for your application. If you do not receive an email, your application has been returned for correction.

The quickest way to determine when your RPE temporary license has been issued is by checking our website everyday under Online License Verification. When checking the website enter only your last name, when you see your full name click on it to obtain your licensing information. You may begin working on the ISSUE date of the RPE temporary license. You will receive the approval letter in 5-7 days from the issue date and the actual licenses in 3-4 weeks.

The approval letter will contain a list of the items needed to complete your file. Once all documents have been received, you will receive a courtesy email.

Remember to keep your address of record current with the Board as government mail may not forward.

Application Checklist for Speech-Language Pathologists

Required Professional Experience
(US Graduates)

Items 1-5 are required for issuance of the temporary license. PRIOR APPROVAL IS REQUIRED. *NOTE: DOJ and FBI* ***clearances*** *must be received prior to issuance.*

1. **Application**

2. **License Fees**
   - Check or Money Order for $60. made payable to SLPAHADB.

3. **Acknowledgement Statement**

4. **RPE Supervisor Responsibility Statement**

5. **Fingerprints**
   - California applicant, must use Livescan; send copy of your form to the Board. Fees paid directly to Livescan Operator.

   - If out-of-state, send two fingerprint cards (FD-258) and $49 to cover DOJ and FBI. You may submit one check or money order in the amount of $109.

Items 6-10 must be submitted within 30 days of issuance of your temporary license.

6. **Transcripts**
   - Sent directly from the universities.

7. **Copy of Diplomas**
   - If not posted on transcript

8. **Clinical Practicum**
   - Must be on our form and mailed directly to the Board from the university.

9. **National Exam Score**
   - Must have minimum passing score of 600, after 09/01/2014 minimum Passing score of 162.
   - Must be within five years.
   - Must be sent electronically from Praxis to our Board.

10. **RPE Verification Form**
    - Submit within 10 days upon RPE completion.
    - Submit a separate verification form for each public school year.
    - Provide a calendar for each school year.
    - Letter from the school district defining the dates and hours of the summer session.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY& HEARING AID DISPENSERS BOARD
2005 EVERGREEN STREET, SUITE 2100, SACRAMENTO, CA 95815
PHONE (916) 263-2666 FAX (916) 263-2668 WWW.SPEECHANDHEARING.CA.GOV

REQUIRED PROFESSIONAL EXPERIENCE TEMPORARY LICENSE APPLICATION FOR SPEECH-LANGUAGE PATHOLOGY $60.00

OFFICE USE ONLY	
RECEIPT #:	
ATS #:	
AMOUNT PAID:	
DATE CASHIERED:	

INSTRUCTIONS: YOU MUST COMPLETE PART A AND YOUR SUPERVISOR MUST COMPLETE PART B. ANY CORRECTIONS TO THIS FORM MUST BE STRICKEN AND INITIALED. **DO NOT USE WHITE OUT OR CORRECTION TAPE ON THIS APPLICATION!** IF ANY SECTIONS ARE NOT COMPLETE, THE ENTIRE APPLICATION PACKET WILL BE RETURNED. YOU MUST INCLUDE A CHECK OR MONEY ORDER FOR $60.00 MADE PAYABLE TO SLPAHADB ALONG WITH THIS APPLICATION. YOU MAY NOT BEGIN WORKING UNTIL THE RPE TEMPORARY LICENSE HAS BEEN ISSUED.

NOTICE: EFFECTIVE JULY 1, 2012, THE STATE BOARD OF EQUALIZATION, AND THE FRANCHISE TAX BOARD MAY SHARE TAXPAYER INFORMATION WITH THE BOARD. YOU ARE OBLIGATED TO PAY YOUR STATE TAX OBLIGATION AND YOUR LICENSE MAY BE SUSPENDED IF THE STATE TAX OBLIGATION IS NOT PAID.

PART A - PERSONAL INFORMATION (PLEASE TYPE OR PRINT NEATLY)

1. FULL NAME: LAST FIRST MIDDLE

2. OTHER NAMES YOU HAVE USED (INCLUDING MAIDEN):

3. *ADDRESS: STREET

CITY, STATE, ZIP CODE

4. RESIDENCE TELEPHONE: BUSINESS TELEPHONE:

5. SOCIAL SECURITY NUMBER: DATE OF BIRTH: (MM/DD/YYYY)

EMAIL ADDRESS:

6. BASIS FOR FILING:

MASTER'S DEGREE ☐ MASTER'S DEGREE EQUIVALENCY ☐

*YOUR ADDRESS IS PUBLIC INFORMATION AND WILL BE PLACED ON THE INTERNET.

7. GRADUATE AND UNDERGRADUATE PROGRAMS.

INSTITUTION NAME	CITY/STATE	MAJOR FIELD OF STUDY	DEGREE TYPE	DATE (MM/DD/YYYY)

PRINT APPLICANTS FULL NAME _____ SOCIAL SECURITY NUMBER _____

8. HAVE YOU TAKEN THE EDUCATIONAL TESTING SERVICE/NATIONAL TEACHER EXAMINATION (NTE) (THE PRAXIS SERIES) IN SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY WITHIN THE PREVIOUS 5 YEARS?

YES _____ NO _____

NOTE: YOU MUST HAVE THE EDUCATIONAL TESTING SERVICE (PRAXIS SERIES) SEND STANDARD SCORE EXAMINATION RESULTS DIRECTLY TO OUR OFFICE.

9. HAVE YOU COMPLETED ANY PORTION OF YOUR CFY/RPE IN ANOTHER STATE?

YES _____ NO _____ IF YES, LIST THE STATE(S):_____

IF YOU WISH TO USE THIS EXPERIENCE YOU WILL BE REQUIRED TO SUBMIT A REQUIRED PROFESSIONAL EXPERIENCE VERIFICATION FORM.

10. HAVE YOU EVER BEEN LICENSED TO PRACTICE SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, OR HEARING AID DISPENSING IN ANY STATE OR COUNTRY?

YES _____ NO _____ IF YES, WHAT STATE(S) OR COUNTRY _____

11. DO YOU HAVE ANY PENDING OR HAVE YOU EVER HAD ANY DISCIPLINARY ACTION TAKEN OR CHARGES FILED AGAINST A SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS LICENSE? INCLUDE ANY DISCIPLINARY ACTIONS TAKEN BY ANY STATE OR OTHER U.S. FEDERAL GOVERNMENT ENTITY.

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

DISCIPLINARY ACTION INCLUDES, BUT IS NOT LIMITED TO, SUSPENSION, REVOCATION, PROBATION, CONFIDENTIAL DISCIPLINE, CONSENT ORDER, LETTER OF REPRIMAND OR WARNING, OR ANY OTHER RESTRICTIONS OF ACTION TAKEN AGAINST A SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY LICENSE.

12. ARE THERE ANY PENDING INVESTIGATIONS BY ANY STATE OR FEDERAL AGENCIES AGAINST YOU?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

13. HAVE YOU EVER BEEN THE SUBJECT OF ANY DISCIPLINARY ACTION REGARDING ANY SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS LICENSE, WHICH YOU NOW HOLD OR HAVE PREVIOUSLY HELD?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

14. HAVE YOU EVER BEEN DENIED A LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS, IN ANY STATE?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

15. HAVE YOU EVER VOLUNTARILY SURRENDERED A LICENSE TO PRACTICE SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY, HEARING AID DISPENSING, OR OTHER HEALING ARTS IN ANOTHER STATE?

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

16. HAVE YOU EVER BEEN CONVICTED OF, OR PLED NOLO CONTENDERE TO ANY OFFENSE, MISDEMEANOR OR FELONY OF ANY STATE, THE UNITED STATES OR A FOREIGN COUNTRY? (EXCEPT VIOLATIONS OF TRAFFIC LAWS RESULTING IN FINES OF $300 OR LESS)

YES _____ NO _____ IF YES, COMPLETE THE CONVICTION/LICENSE DISCIPLINARY ACTION FORM

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND/OR DISMISSED UNDER PENAL CODE SECTION 1203.4 OR UNDER ANY OTHER PROVISION OF THE LAW.

YOU MUST REPORT TO THE BOARD THE RESULT OF ANY ACTIONS WHICH HAVE BEEN FILED OR WERE PENDING AGAINST ANY SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY LICENSE YOU HOLD AT THE FILING OF THIS APPLICATION. FAILURE TO REPORT THIS INFORMATION MAY RESULT IN THE DENIAL OF YOUR APPLICATION OR SUBJECT YOUR LICENSE TO DISCIPLINE PURSUANT TO SECTION 480 (C) OF THE BUSINESS AND PROFESSIONS CODE.

ATTACH 2" X 2" OR 3" X 3"
PASSPORT QUALITY
PHOTOGRAPH HERE. YOU MUST PRINT YOUR FULL NAME ON THE BACK OF THE PHOTOGRAPH. THE PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE 60 DAYS OF THE FILING DATE OF THIS APPLICATION.

PHOTOS PRINTED ON WHITE BOND PAPER ARE **NOT** ACCEPTABLE.

PRINT APPLICANTS FULL NAME _____ SOCIAL SECURITY NUMBER _____

PART B – TO BE COMPLETED BY THE SUPERVISOR. REFER TO TITLE 16, CALIFORNIA CODE OF REGULATIONS, SECTION 1399.153.3 FOR SUPERVISOR'S RESPONSIBILITIES.

19. START DATE:

AS SOON AS POSSIBLE (APPROVED) ☐ FUTURE DATE: _____

YOU MAY **NOT** BEGIN WORKING ON THIS DATE UNLESS YOU HAVE RECEIVED APPROVAL FROM THIS OFFICE.

20. NUMBER OF RPE EMPLOYMENT HOURS PER WEEKS:

☐ 30-40 (FULL-TIME) ☐ 15-29 (PART-TIME)

21. LIST OF PLACE(S) WHERE FUNCTIONS WILL BE PERFORMED:

FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE

FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE

FACILITY OR SCHOOL NAME (DO NOT USE ABBREVIATIONS) ADDRESS CITY, STATE, ZIP CODE

22. IS THE SETTING(S) LISTED IN QUESTION #21 A PUBLIC SCHOOL? YES ☐ NO ☐

IF YES, IS THE RPE:

☐ A SALARIED EMPLOYEE OF THE SCHOOL PUBLIC OR COUNTY OFFICE OF EDUCATION.

☐ PAID BY A CONTRACT AGENCY AND PLACED IN THE PUBLIC SCHOOL.

23. NAME OF SUPERVISOR: LAST FIRST LICENSE NUMBER:

ADDRESS: STREET

CITY, STATE, ZIP CODE:

EMAIL ADDRESS:

24. SUPERVISION:

☐ THE RPE WILL BE WORKING FULL-TIME AND I AGREE TO PROVIDE EIGHT HOURS A MONTH DIRECT SUPERVISION. FOUR OF THE EIGHT WILL BE IN SCREENING, THERAPY, AND EVALUATION.

☐ THE RPE WILL BE WORKING PART-TIME AND I AGREE TO PROVIDE FOUR HOURS A MONTH DIRECT SUPERVISION. TWO OF THE FOUR WILL BE IN SCREENING, THERAPY, AND EVALUATION.

I, THE RPE APPLICANT, HAVE DISCUSSED THE PLAN FOR SUPERVISION WITH THIS SUPEVISOR AND AGREE TO ITS IMPLEMENTATION. I FURTHER CERTIFY UNDER PENATLY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE IN THE APPLICATION ARE TRUE AND CORRECT. ANY MISREPRESENTATION MAY BE CAUSE FOR DENIAL OF MY LICENSE. **THIS APPLICATION MUST BE SIGNED AFTER THE DEGREE HAS BEEN GRANTED/AWARDED.**

APPLICANT'S SIGNATURE _____ DATE SIGNED _____

(SIGNATURE MUST BE IN BLUE INK)

I, THE RPE SUPERVISOR, HAVE DISCUSSED THE PLAN FOR SUPERVSION WITH THE RPE APPLICANT AND HEREBY ACCEPT PROFESSIONAL AND ETHICAL RESPONSIBILITY FOR HIS OR HER PERFORMANCE. I FURTHER CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE IN **PART B** ARE TRUE AND CORRECT.

I FURTHER CERTIFY THAT I HAVE COMPLETED THE INTIAL 6 HOURS OF CONTINUING PROFESSIONAL DEVELOPMENT IN SUPERVISION TRAINING AND WILL COMPLETE 3 HOURS EVERY OTHER RENEWAL CYCLE THEREAFTER.

SUPERVISOR'S SIGNATURE _____ DATE SIGNED _____

(SIGNATURE MUST BE IN BLUE INK)

(Jul-14)

STATE OF CALIFORNIA
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RPE TEMPORARY LICENSE ACKNOWLEDGMENT STATEMENT

RPE temporary license applicants must read and sign this statement. The signed page must be returned with the Temporary Required Professional Experience License application.

As an RPE temporary license holder, I am responsible for ensuring the following standards are complied with during my RPE experience.

1) I have read and understand the excerpts of the laws and regulations, included with my application, pertaining to the responsibilities of an RPE temporary license holder.

2) My supervisor shall maintain a current license issued by the Speech-Language Pathology and Audiology Board during the entire time he or she is supervising my experience. **If my supervisor's license expires during the course of my experience, I will report the situation to the Board for further action.**

   The supervisor's license may be verified at any time at the Board's website at www.speechandhearing.ca.gov.

3) I understand that I must complete 36 weeks of full-time experience (defined as 30-40 hours per week) with 8 hours per month direct supervision or 72 weeks of part-time experience (defined as 15-29 hours per week) with 4 hours per month of direct supervision to be eligible for a permanent license.

4) If there is an extended break in experience due to a vacation or illness, it is my responsibility to notify the Board of the exact dates of the breaks. I will not receive credit for the time identified.

5) Should I decide to alter my RPE plan at any time, it will be my responsibility to ensure that all of the standards set forth in this document and the laws and regulations are complied with for each new RPE plan.

6) As defined in California Code of Regulations Section 1399.153.4., I understand that should my supervisor supervise more than 3 RPE temporary license holders at any time during my experience, I will not receive credit for that time.

7) At the time of termination of supervision, I will ensure that my supervisor completes the Required Professional Experience (Verification) form. I understand that it is my responsibility to return the Verification form within 10 days of completion.

8) The following occurrences will result in a loss of credit in experience:
   - Supervisor's license expired while I was practicing under his/her supervision.
   - Supervisor is supervising more than 3 RPE temporary license holders at any time during my RPE plan.
   - Insufficient hours worked to satisfy part-time requirements (15-29 hours per week) or full-time requirement (30-40 hours per week).
   - Inadequate hours of supervision for part-time requirement (4 hours per month) or full-time requirement (8 hours per month)
   - Unreported break in experience that resulted in an insufficient number of weeks worked.

Please keep this page for your records.

RPE TEMPORARY LICENSE
ACKNOWLEDGMENT STATEMENT
SIGNATURE PAGE

I hereby acknowledge that I have received and read, in its entirety, the RPE Temporary License Acknowledgement Statement. I understand what is expected of me and agree to follow these guidelines. Failure to do so will result in a denial of credit for the professional experience.

_____ _____

Signature of RPE Applicant (in blue ink) Social Security Number

_____ _____

Print Full Name of Applicant Date

_____

Mailing Address

_____

City, State, Zip Code

(Rev Jan-15)

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REQUIRED PROFESSIONAL EXPERIENCE SUPERVISOR RESPONSIBILITY STATEMENT

All qualified speech-language pathologists or audiologists who assume responsibility for providing supervision to a required professional experience (RPE) temporary license holder must complete and sign under penalty of perjury, the following statement.

1) I possess the following qualifications to supervise a speech-language pathology or audiology applicant:

   A California license issued by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, or

   If employed by the public school, a valid, current, and professional clear credential authorizing service in language speech, and hearing issued by the Commission on Teacher Credential.

2) I agree to ensure that either my California license or my official credential is renewed in a timely manner. Failure to do so could result in a loss of credit for experience obtained by the RPE.

3) I agree to provide 8 hours direct supervision per month for each full-time RPE and 4 hours direct supervision per month for each part-time RPE. (Full-time is defined as 30-40 hours per week. Part-time is defined as 15-29 hours per week).

4) I will not supervisor more than 3 RPE's at any one time pursuant to Section 1399.153.4 of the California Code of Regulations.

5) I will immediately notify the RPE of any disciplinary action, including revocation, suspension, even if stayed, probation terms, inactive license, or lapse in licensure that affects my ability or right to supervise.

6) I know and understand the laws and regulations pertaining to the supervision of the RPE's and the experience required.

7) I will ensure that the extent, kind, and quality of the clinical work performed is consistent with the training and experience of the RPE and shall be accountable for the assigned tasks performed by the RPE.

8) At the time of termination of supervision, I will complete the Required Professional Experience Verification form. I will submit the original signed form to the board within 10 calendar days of termination of supervision.

9) I have completed the initial 6 hours of continuing professional development in supervision training and will complete 3 hours every other renewal cycle hereafter.

Please keep this page for your records

REQUIRED PROFESSIONAL EXPERIENCE
SUPERVISOR RESPONSIBILITY STATEMENT
SIGNATURE PAGE

_____ _____
Applicants Full Name Applicants Social Security Number

_____
Address

_____
City State Zip Code

I declare under penalty of perjury under the laws of the State of California that I have read and understand the foregoing. I further certify that all information submitted on this form is true and correct.

_____ _____
Supervisor's Signature (in blue ink) Date

_____ _____
Print Name California License Number or Credential #
(If not licensed, please attach a copy of
the front AND back of your credential.)

_____
Address

_____
City State Zip Code

(Rev Aug-13)

STATE OF CALIFORNIA
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2005 Evergreen Street, Suite 2100, Sacramento, CA 95815
Phone: (916) 263-2666 Fax: (916) 263-2668 Web: www.speechandhearing.ca.gov

CLINICAL PRACTICUM VERIFICATION

REQUIREMENTS:
A minimum of 300 clock hours must be completed in 3 different settings under the supervision of a licensed Speech-Language Pathologist or Audiologist as defined in section 1399.152.2 of the California Code of Regulations.

A maximum of 25 hours may be obtained in a field other than that for which the applicant is seeking licensure. (For example: audiology for a speech pathology applicant or speech pathology for an audiology applicant.)

This form must be completed and submitted directly to the board by the training program director.
DO NOT USE WHTE OUT OR CORRECTION TAPE ON THIS FORM.

APPLICANT INFORMATION:

1. NAME: LAST FIRST MIDDLE	
2. SOCIAL SECURITY NUMBER:	3. DATE OF BIRTH: (MM/DD/YYYY)

UNIVERSITY & TRAINING PROGRAM DIRECTOR INFORMATION:

4. COLLEGE OR UNIVERSITY:
5. TRAINING PROGRAM DIRECTOR'S NAME:
6. LICENSE NUMBER OR ASHA CERTIFICATION NUMBER:

VERIFICATION:

	YES	NO
7. THE APPLICANT HAS COMPLETED A MINIMUM OF 300 CLOCK HOURS OF SUPERVISED CLINICAL EXPERIENCE IN DIRECT CLIENT/PATIENT CONTACT.	☐	☐
8. THE APPLICANT HAS OBTAINED CLOCK HOURS IN A MINUMUM OF THREE DIFFERENT SETTING.	☐	☐
9. THE APPLICANT HAS COMPLETED THE CLOCK HOURS WHILE ENGAGED IN GRADUATE PROGRAM.	☐	☐
10. THE APPLICANT HAS GAINED KNOWLEDGE AND EXPERIENCE WITH CLIENTS/PATIENTS OF ALL AGES.	☐	☐
11. THE APPLICANT HAS BEEN SUPERVISED BY INDIVIDUAL(S) HOLDING CURRENT/VALID ASHA CERTIFICATION OR STATE LICENSURE IN SPEECH PATHOLOGY OR AUDIOLOGY.	☐	☐
12. THE AMOUNT OF SUPERVISION WAS APPROPRIATE TO THE STUDENT'S LEVEL OF KNOWLEDGE, EXPERIENCE & COMPETENCE, AND WAS SUFFICIENT TO ENSURE THE WELFARE OF THE CLIENTS/PATIENTS.	☐	☐

I certify that all practicum information listed on this form was completed according to all ASHA and State of California practicum requirements.

SIGNATURE OF CURRENT TRAINING PROGRAM DIRECTOR IN BLUE INK

DATE SIGNED

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REQUIRED PROFESSIONAL EXPERIENCE VERIFICATION FORM

INSTRUCTIONS AND IMPORTANT INFORMATION: This form must be completed and submitted within 10 business days of termination of supervision, change in time base or at the end of your experience. Full-time and part-time experience can not be combined on the same form. If you are working in a public school you will be required to submit a separate verification form for each school year. You must also provide a calendar for each school year. If you work during the summer you will be required to submit a separate verification form for the summer session. You will also be required to provide a letter from the school district that defines the dates and hours of the summer school session. Any corrections to this form must be stricken and initialed by the supervisor. Do **NOT** use white out or correction tape on this form. Do **not** fax this form to the Board.

THIS SECTION MUST BE COMPLETED BY THE APPLICANT.

1. APPLICANT'S NAME: LAST FIRST MIDDLE

2. APPLICANT'S ADDRESS OF RECORD: WOULD YOU LIKE YOUR ADDRESS CHANGED? _____ YES _____ NO

_____
SIGNATURE AUTHORIZING ADDRESS CHANGE

CITY, STATE, ZIP CODE: PHONE NUMBER:

3. SOCIAL SECURITY NUMBER: RPE NUMBER: DATE OF BIRTH: (MM/DD/YY)

EMAIL ADDRESS:

THIS SECTION MUST BE COMPLETED BY THE SUPERVISOR.

4. SUPERVISOR'S NAME: LAST FIRST LICENSE NUMBER:

5. SUPERVISOR'S ADDRESS:

CITY, STATE, ZIP CODE:

EMAIL ADDRESS:

6. LOCATION(S) WHERE EXPERIENCE WAS ACTUALLY OBTAINED: (DO NOT PROVIDE AGENCY INFORMATION)

_____
FACILITY OR SCHOOL NAME ADDRESS CITY, STATE, ZIP CODE

_____
FACILITY OR SCHOOL NAME ADDRESS CITY, STATE, ZIP CODE

7. NUMBER OF HOURS APPLICANT WORKED PER WEEK:

8. DATES OF EXPERIENCE: (MM/DD/YY)
(MUST REFLECT ONLY THE DATES **YOU** PROVIDED SUPERVISION)

FROM: / / TO: / /

*DOCTORATE OF AUDIOLOGY STUDENTS **ONLY**. THIS APPLICANT HAS COMPLETED THE 4TH YEAR (12-MONTH EXTERNSHIP) AS REQUIRED BY THE AUDIOLOGY DOCTORAL PROGRAM:

YES ____ NO ____

PRINT APPLICANTS FULL NAME _____ RPE NUMBER _____

9. WAS THE APPLICANT EMPLOYED AS A SALARIED EMPLOYEE OF A PUBLIC SCHOOL (COUNTY OFFICE OF EDUCATION)?

YES _____ NO _____

A. WHAT WAS THE SCHOOL SCHEDULE: TRADITIONAL _____ YEAR ROUND _____ SUMMER SCHOOL _____

YOU MUST ATTACH A SCHOOL CALENDAR THAT REFLECTS THE NAME OF SCHOOL OR DISTRICT AND ALL SCHOOL BREAKS AND HOLIDAYS.

WILL THE APPLICANT CONTINUE TO WORK UNDER YOUR SUPERVISION IN THE FALL?

YES _____ NO _____

10. SUPERVISION: (CHECK ONE)

_____ THE RPE WORKED FULL-TIME AND I PROVIDED EIGHT HOURS A MONTH OF DIRECT SUPERVISION. FOUR OF THE EIGHT HOURS WERE IN SCREENING, THERAPY, AND EVALUATION.

_____ THE RPE WORKED PART-TIME AND I PROVIDED FOUR HOURS A MONTH OF DIRECT SUPERVISION. TWO OF THE FOUR HOURS WERE IN SCREENING, THERAPY, AND EVALUATION

_____ THIS SETTING WAS LESS THAN FIFTEEN HOURS PER WEEK. SUPERVISION WAS PROVIDED AS REQUIRED.

11. PERFORMANCE OF RPE APPLICANT WAS: SATISFACTORY ☐ UNSATISFACTORY ☐

COMMENTS:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT I HAVE DISCUSSED THE FOREGOING WITH THE APPLICANT AND THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT, AND I DID NOT SUPERVISE MORE THAN TWO (2) OTHER APPLICANTS OBTAINING THEIR REQUIRED PROFESSIONAL EXPERIENCE (RPE) DURING THE SAME PERIOD OF TIME. I FURTHER CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE HEREIN ARE TRUE IN EVERY RESPECT, AND THAT MISSTATEMENTS OR OMISSIONS OF MATERIAL FACTS MAY BE CAUSE FOR DENIAL OF THIS VERIFICATION, OR FOR SUSPENSION OR REVOCATION OF MY LICENSE.

_____ DATE

_____ SUPERVISOR'S SIGNATURE (IN BLUE INK)

INFORMATION COLLECTION AND ACCESS

THE SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD'S EXECUTIVE OFFICER IS THE PERSON WHO IS RESPONSIBLE FOR INFORMATION MAINTENANCE. SECTION 2532 OF THE BUSINESS AND PROFESSIONS CODE IS THE AUTHORITY, WHICH AUTHORIZES THE MAINTENANCE OF THE INFORMATION. ALL INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY MANDATORY INFORMATION WILL RESULT IN THE APPLICATION BEING REJECTED AS INCOMPLETE. THE INFORMATION PROVIDED WILL BE USED TO DETERMINE QUALIFICATION FOR LICENSURE. EACH INDIVIDUAL HAS THE RIGHT TO REVIEW HIS OR HER FILE MAINTAINED BY THE AGENCY SUBJECT TO THE PROVISIONS OF THE CALIFORNIA PUBLIC RECORDS ACT.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (check one) ___ Employment X License, Certification, Permit ___ Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
Agency authorized to receive criminal history information

06187
Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100
Street No. Street or PO Box

N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ___ Male ___ Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: 7700 SLP/AU
OCA No. (Agency Identifying No.)

Level of Service DOJ X FBI X

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (check one) ___ Employment X License, Certification, Permit ___ Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
Agency authorized to receive criminal history information

06187
Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100
Street No. Street or PO Box

N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ___ Male ___ Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: 7700 SLP/AU
OCA No. (Agency Identifying No.)

Level of Service DOJ X FBI X

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

BCII 8016 (Rev10/98) **ORIGINAL-Live Scan Operator; SECOND COPY-Requesting Agency; THIRD COPY-Applicant**

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (check one) ___ Employment X License, Certification, Permit ___ Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Speech Aide Audiology Aide

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Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

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